General

Guideline Title

Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care.

Bibliographic Source(s)

National Collaborating Centre for Mental Health. Childrenâ€™s attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Nov 25. 42 p. (NICE guideline; no. 26).

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): The guideline was developed by the National Collaborating Centre for Mental Health (NCCMH) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation) and is defined at the end of the "Major Recommendations" field.

Refer to the original guideline document for definitions of terms used in this guideline.

Principles of Care in All Contexts

Using This Guideline

Use this guideline in conjunction with the NICE public health guideline on looked-after children and young people and the NICE clinical guideline on when to suspect child maltreatment.

Ensuring Equal Access to Consistent Care

Ensure that all children, young people and their parents or carers get equal access to interventions for attachment difficulties, regardless of whether they:

- Are on the edge of care, accommodated under Section 20 of the Children Act 1989, subject to a care order, under special guardianship or adopted from care
- Are placed with birth parents, foster carers (including kinship carers), special guardians or in residential care
- Are from a minority ethnic group
- Have a disability or a mental health problem
- Are from the United Kingdom (UK) or overseas

Assess all children and young people who enter the UK as unaccompanied asylum-seeking children for attachment difficulties once a stable placement has been found, and offer interventions and support if needed. Take into account that, in addition to attachment difficulties, children and young people who enter the UK as unaccompanied asylum-seeking children are highly likely to have been traumatised, especially when coming from war zones. If they have post-traumatic stress disorder, offer treatment in line with the NICE guideline on post-traumatic stress disorder.

Ensure that the health, education and social care processes and structures surrounding children and young people with attachment difficulties are stable and consistent. This should include:

- Using a case management system to coordinate care and treatment
- Collaborative decision making among all health, education and social care professionals, the child or young person if possible and their parents and carers
- Having the same key worker, social worker, personal adviser or key person in school throughout the period the child or young person is in the care system or on the edge of care

Ensure that the stability or instability of the child or young person's placement does not determine whether psychological interventions or other services are offered.

Improving the Stability of Placements

Ensure that, whenever possible, children and young people enter the care system in a planned manner rather than in response to a crisis.

Ensure that carers are ready to accept the child or young person's need to be in a loving relationship and are able and, whenever possible, willing to think about providing longer-term care or involvement if needed.

Help arrange kinship placements, if safe and in the best interest of the child or young person.

Consider comprehensive education and training for potential carers to prepare them for the challenges involved in looking after children and young people with attachment difficulties and the likely impact on them and their families.

Provide ongoing support and advice, either by telephone or in person, and proactively monitor difficulties in placements to identify opportunities to provide additional support, if there are significant attachment difficulties or if disruption to the placement is likely.

If a placement breaks down, aim to maintain the relationship between the child or young person and the foster carers (including kinship carers), adoptive parents or special guardians, whenever possible and if it is in the best interests of the child or young person.

Preparing the Child or Young Person before They Enter the Care system or Change Placement

Actively involve children and young people, and their parents or current carers, in the process of entering the care system or changing placement. This may include:

- Explaining the reasons for the move

- Familiarising the child or young person with their new carers and placement (for example, by arranging a pre-placement visit or showing them photographs of their new carers and home)
- Providing ongoing support during transitions, such as face-to-face meetings, telephone conversations and other appropriate methods of communication
- Making sure the child or young person has the opportunity to ask questions and make choices whenever appropriate and possible
- Supporting the child or young person in maintaining relationships with their parents or previous carers unless this would not be in the child or young person's best interests
- Taking account of the needs of children at different ages and developmental stages, including needs related to their mental health and any physical disabilities

Improving the Likelihood of a More Permanent Placement, Including Adoption

If a return to the birth parents or original family is not an option, keep siblings together if it is possible and in the best interests of all the children or young people.

Offer additional support and resources (such as mentoring or day visits with a social worker) to children and young people and/or their carers:

- At the first sign of serious difficulties in the placement, or
- If there have been frequent changes of placement, or
- If there is more than one child with attachment difficulties in the placement

When adoption is considered the best outcome for the child or young person ensure that:

- Their wishes are taken into account
- They are offered information that is appropriate to their developmental level about the implications that adoption may have for future contact with their birth parents, siblings, wider family members and others
- A full assessment of need is conducted before adoption
- An assessment of attachment difficulties is offered at any stage after adoption
- They are offered support (based on the assessment of need and attachment difficulties) before, during and after adoption

Preserving the Personal History of Children and Young People

Social care workers should offer children and young people in the care system, in special guardianship or adopted from care, accurate, comprehensive, up-to-date and age-appropriate information about their history and family in a form that they are able to use and revisit at their own pace (for example, through photographs and life story work in line with the NICE guideline on looked after children and young people).

Social care workers should keep a record of the significant people and places in the child or young person's life while they are in the care system.

Safeguarding and Monitoring During Interventions

Ensure safeguarding is maintained during any intervention for a child or young person with attachment difficulties.

Consider using a parental sensitivity tool (for example the Ainsworth Maternal Sensitivity Scale) and a parenting quality tool with parents and carers to help guide decisions on interventions and to monitor progress.

Pharmacological Interventions

Do not treat attachment difficulties with pharmacological interventions. For the use of pharmacological interventions for coexisting mental health problems, see the NGC summaries of the NICE guidelines Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and

management (NICE clinical guideline 158), Attention deficit hyperactivity disorder: diagnosis and management (NICE clinical guideline 72), and Depression in children and young people: identification and management in primary, community and secondary care (NICE clinical guideline 28), and the NICE clinical guideline Alcohol-use disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline 115).

Supporting Children and Young People with Attachment Difficulties in Schools and Other Education Settings (Including Early Years)

Schools and other education providers should ensure that all staff who may come into contact with children and young people with attachment difficulties receive appropriate training on attachment difficulties, as set out in the following recommendation.

Educational psychologists and health and social care provider organisations should work with local authority virtual school heads and designated teachers to develop and provide training courses for teachers of all levels on:

- How attachment difficulties begin and how they can present in children and young people
- How attachment difficulties affect learning, education and social development
- Understanding the consequences of maltreatment, including trauma
- How they can support children and young people with attachment difficulties. Children and young people with attachment difficulties, and their parents or carers, should be involved in the design of the training courses, wherever possible.

Staff in schools and other education settings and health and social care professionals should work together to ensure that children and young people with attachment difficulties:

- Can access mental health services for children and young people and education psychology services for interventions
- Are supported at school while they are taking part in interventions following advice from mental health services for children and young people and education psychology services

When providing support for interventions in schools and education settings, staff should:

- Be aware of the possibility of stigma, bullying and labelling as a result of any absences from school
- Take into account the child or young person's preferences for the setting of the intervention

Schools and other education providers should ensure that the designated teacher:

- Has had specialist training:
  - To recognise and understand attachment difficulties and mental health problems
  - In data protection and confidentiality
- Is aware of and keeps accurate and comprehensive records about all children and young people in their school who:
  - Are in the care system
  - Have been adopted or subject to special guardianship orders
  - Have or may have attachment difficulties
- Has contact details for the parents, carers and health and social care professionals for all the above groups
- Maintains an up-to-date plan (a personal education plan for children and young people in the care system) setting out how they will be supported in school
- Provides a key person who can advocate for the child or young person and to whom the child or young person can go for support
- Allocates a safe place in school, for example a room where a child or young person can go if they are distressed
- Attends looked-after children reviews
- Maintains an effective referral system with other agencies

Social care professionals, schools and other education providers should ensure that changes or gaps in the education of children and young people in the care system are avoided by:

- Helping them to keep attending school when there are changes to their placements
- Supporting them while they develop new relationships and if they are worried about the new placement. If a change is unavoidable, it should be planned in advance so that disruption is minimal

Schools and other education providers should avoid using permanent and fixed-term school exclusion as far as possible for children and young people in the care system with identified attachment difficulties.

Assessing Attachment Difficulties in Children and Young People in All Health and Social Care Settings

Health and social care provider organisations should train key workers, social care workers, personal advisers and post-adoption support social workers in the care system, as well as workers involved with children and young people on the edge of care, in:

- Recognising and assessing attachment difficulties and parenting quality, including parental sensitivity
- Recognising and assessing multiple socioeconomic factors (for example, low income, single or teenage parents) that together are associated with an increased risk of attachment difficulties
- Recognising and assessing other difficulties, including coexisting mental health problems and the consequences of maltreatment, including trauma
- Knowing when and how to refer for evidence-based interventions for attachment difficulties (see "Interventions for Attachment Difficulties in Children and Young People on the Edge of Care," "Interventions for Attachment Difficulties in Children and Young People in the Care System, Subject to Special Guardianship Orders and Adopted from Care," and "Interventions for Attachment Difficulties in Children and Young People in Residential Care" below)

Health and social care professionals should offer a child or young person who may have attachment difficulties, and their parents or carers, a comprehensive assessment before any intervention, including:

- Personal factors, including the child or young person's attachment pattern and relationships
- Factors associated with the child or young person's placement, such as history of placement changes, access to respite and trusted relationships within the care system or school
- The child or young person's educational experience and attainment
- Parental sensitivity
- Parental factors, including conflict between parents (such as domestic violence and abuse), parental drug and alcohol misuse or mental health problems, and parents' and carers' experiences of maltreatment and trauma in their own childhood
- The child or young person's experience of maltreatment or trauma
- The child or young person's physical health
- Coexisting mental health problems and neurodevelopmental conditions commonly associated with attachment difficulties, including antisocial behaviour and conduct disorders, attention deficit hyperactivity disorder, autism, anxiety disorders (especially post-traumatic stress disorder), depression, alcohol misuse and emotional dysregulation

Offer children and young people who have or may have attachment difficulties, and who also have a mental health problem or neurodevelopmental condition, interventions as recommended in the relevant NICE guideline (see the NGC summaries of the NICE clinical guidelines Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management [NICE clinical guideline 158], Attention deficit hyperactivity disorder: diagnosis and management [NICE clinical guideline 72], Autism: recognition, referral, diagnosis and management of adults on the autism spectrum [NICE clinical guideline 128], Social anxiety disorder: recognition, assessment and treatment [NICE clinical guideline 159], Depression in children and young people: identification and management in primary, community and secondary care [NICE clinical guideline 28], and the NICE clinical guidelines Alcohol-use disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence [NICE clinical guideline 115] andPost-traumatic stress disorder: management

[NICE clinical guideline 26]).

Consider using the following assessment tools to guide decisions on interventions for children and young people who have or may have attachment difficulties:

- Strange Situation Procedure for children aged 1 to 2 years
- Modified versions of the Strange Situation Procedure for children aged 2 to 4 years (either the Cassidy Marvin Preschool Attachment Coding System or the Preschool Assessment of Attachment)
- Attachment Q-sort for children aged 1 to 4 years
- Manchester Child Attachment Story Task, McArthur Story Stem Battery and Story Stem Attachment Profile for children aged 4 to 7 years
- Child Attachment Interview for children and young people aged 7 to 15 years
- Adult Attachment Interview for young people (aged 15 years and over) and their parents or carers

See the table in Appendix 1 of the original guideline document for further information about these tools.

Health and social care provider organisations should ensure that health and social care professionals are skilled in the use of the assessment tools in the above recommendation.

Only diagnose an attachment disorder if a child or young person has attachment difficulties that meet diagnostic criteria as defined in the Diagnostic and statistical manual of mental disorders, 5th edition (DSM-5; reactive attachment disorder and disinhibited social engagement disorder) or the International classification of diseases and related health problems, 10th revision (ICD-10; reactive attachment disorder and disinhibited attachment disorder).

Do not offer genetic screening (including measuring specific gene polymorphisms) in children and young people to predict or identify attachment difficulties.

If, following assessment of attachment difficulties, an intervention is required, refer the child or young person, and their parents or carers, to a service that:

- Has specialist expertise in attachment difficulties in children and young people and their parents or carers
- Works with other services, including mental health services for children and young people, education and social care
- Actively involves children and young people with attachment difficulties in staff training programmes

Interventions for Attachment Difficulties in Children and Young People on the Edge of Care

This section covers children and young people with attachment difficulties (or at risk of attachment difficulties) who currently live with their birth parents or original family and who are at high risk of entering or re-entering the care system. It also covers children and young people who have been maltreated or are at high risk of being maltreated (see recommendations below).

Preschool-age Children with, or at Risk of, Attachment Difficulties

Health and social care professionals should offer a video feedback programme to the parents of preschool-age children on the edge of care to help them:

- Improve how they nurture their child, including when the child is distressed
- Improve their understanding of what their child's behaviour means
- Respond positively to cues and expressions of the child's feelings
- Behave in ways that are not frightening to the child
- Improve mastery of their own feelings when nurturing the child

Ensure video feedback programmes are delivered in the parental home by a trained health or social care worker who has experience of working with children and young people and:

- Consist of 10 sessions (each lasting at least 60 minutes) over 3 to 4 months

- Include filming the parents interacting with their child for 10 to 20 minutes every session
- Include the health or social care worker watching the video with the parents to:
  - Highlight parental sensitivity, responsiveness and communication
  - Highlight parental strengths
- Acknowledge positive changes in the behaviour of the parents and child

If there is little improvement to parental sensitivity or the child's attachment after 10 sessions of a video feedback programme for parents of preschool-age children on the edge of care, arrange a multi-agency review before going ahead with more sessions or other interventions.

If parents do not want to take part in a video feedback programme, offer parental sensitivity and behaviour training to help them:

- Understand their child's behaviour
- Improve their responsiveness to their child's needs
- Manage difficult behaviour

Ensure parental sensitivity and behaviour training:

- First consists of a single session with the parents followed by at least 5 (and up to 15) weekly or fortnightly parent–child sessions (lasting 60 minutes) over a 6-month period
- Is delivered by a trained health or social care professional
- Includes:
  - Coaching the parents in behavioural management (not applicable for children aged 0 to 18 months) and limit setting
  - Reinforcing sensitive responsiveness
  - Ways to improve parenting quality
- Homework to practise applying new skills

If parents do not want to take part in a video feedback programme or parental sensitivity and behaviour training, or, if there is little improvement to parental sensitivity or the child's attachment after either intervention and there are still concerns, arrange a multi-agency review before going ahead with more interventions.

If the multi-agency review concludes that further intervention is appropriate, consider a home visiting programme to improve parenting skills delivered by an appropriately-trained lay home visitor or a healthcare professional such as a nurse.

Ensure home visiting programmes:

- Consist of 12 weekly or monthly sessions (lasting 30–90 minutes) over an 18-month period
- Include observing the child (not using video) with their parents
- Give the parents advice about how they can improve their communication and relationship with their child by:
  - Supporting positive parent–child interaction using role modelling
  - Reinforcing positive interactions and parental empathy
- Provide parental education and guidance about child development

Preschool-age Children Who Have Been or Are at Risk of Being Maltreated

Consider parent–child psychotherapy for parents who have maltreated or are at risk of maltreating their child to improve attachment difficulties, ensuring that safeguarding concerns are addressed.

Ensure parent–child psychotherapy to improve attachment difficulties:

- Is based on the Cicchetti and Toth model (Cicchetti D, Rogosch FA, Toth SL [2006] Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology* 18: 623–49 and Toth SL, Maughan A, Manly JT et al. [2002] The relative efficacy of two interventions in altering maltreated preschool children's representational models: implications

for attachment theory. *Development and Psychopathology* 14: 877–908.)
Consists of weekly sessions (lasting 45–60 minutes) over 1 year
Is delivered in the parents' home by a therapist trained in the intervention
Directly observes the child and the parent–child interaction
Explores the parents' understanding of the child's behaviour
Explores the relationship between the emotional reactions of the parents and perceptions of the child, and the parents' own childhood experiences

Primary and Secondary School-age Children and Young People with, or at Risk of, Attachment Difficulties

Consider parental sensitivity and behaviour training for parents of primary and secondary school-age children and young people (as described above) to improve attachment difficulties, adapting the intervention for the age of the child or young person.

Primary and Secondary School-age Children and Young People Who Have Been, or Are at Risk of Being, Maltreated

For children and young people who have been maltreated, and show signs of trauma or post-traumatic stress disorder, offer trauma-focused cognitive behavioural therapy, and other interventions in line with the NICE guideline on post-traumatic stress disorder .

Consider parental sensitivity and behaviour training (as described above) for parents at risk of maltreating their child to improve attachment difficulties, ensuring that safeguarding concerns are addressed and adapting the intervention for the age of the child or young person.

Interventions for Attachment Difficulties in Children and Young People in the Care System, Subject to Special Guardianship Orders and Adopted from Care

This section covers children and young people with attachment difficulties (or at risk of attachment difficulties) who are in the care system, subject to special guardianship orders or adopted from care; it also covers their foster carers (including kinship carers), special guardians and adoptive parents.

Preschool-age Children

Health and social care professionals should offer a video feedback programme to foster carers, special guardians and adoptive parents, as described in the recommendation in the section "Preschool-age Children with, or at Risk of, Attachment Difficulties" above.

If there is little improvement to parental sensitivity or the child's attachment after 10 sessions of a video feedback programme for foster carers, special guardians and adoptive parents of preschool-age children, arrange a multi-agency review before going ahead with more sessions or other interventions.

If foster carers, special guardians or adoptive parents do not want to take part in a video feedback programme, offer parental sensitivity and behaviour training as described in the recommendation in the section "Preschool-age Children with, or at Risk of, Attachment Difficulties" above.

Primary School-age Children

Consider intensive training and support for foster carers, special guardians and adoptive parents before the placement and for 9 to 12 months after, combined with group therapeutic play sessions for the child for the same duration (see recommendation below).

Ensure intensive training for foster carers, special guardians and adoptive parents includes:

Positive behavioural management methods
Help with peer and parent/carer relationships for the child
Support for schoolwork
Help to defuse conflict

Ensure intensive support for foster carers, special guardians and adoptive parents includes:

- Supervision by daily telephone contact
- Weekly support group meetings
- A 24-hour crisis intervention telephone line

Ensure group therapeutic play sessions for primary school-age children after placement:

- Consist of weekly sessions (lasting 60–90 minutes) over the 9- to 12-month period
- Are delivered by a trained health or social care professional
- Include monitoring of behavioural, social and developmental progress

Late Primary and Early Secondary School-age Children and Young People

Consider a group-based training and education programme for foster carers, special guardians and adoptive parents to maintain stability in the home and help transition to a new school environment (see the next recommendation), combined with a group-based training and education programme for late primary and early secondary school-age children and young people in the care system, subject to special guardianship orders and adopted from care to improve social skills and maintain positive peer relationships (see recommendation below in this section).

Ensure group-based training and education programmes for foster carers, special guardians and adoptive parents:

- Consist of twice-weekly sessions (lasting 60–90 minutes) in a group for the first 3 weeks, then weekly sessions over the remaining school year
- Are delivered by a trained facilitator
- Have a behavioural reinforcement system to encourage adaptive behaviours across home, school and community settings
- Provide weekly telephone support if needed
- Give homework to practise applying new skills

Ensure training and education programmes for late primary and early secondary school-age children and young people in the care system, subject to special guardianship orders and adopted from care:

- Consist of twice-weekly sessions (lasting 60–90 minutes) in a group for the first 3 weeks, then individual weekly sessions over the remaining school year
- Are delivered by trained mentors, which may include graduate level workers, at a time that ensures schooling is not disrupted
- Teach skills to help reduce involvement with peers who may encourage misbehaviour, and to increase their levels of self-confidence
- Encourage them to get involved in a range of educational, social, cultural and recreational activities
- Help them develop a positive outlook

Modify interventions for young people in the care system, subject to special guardianship orders and adopted from care when needed to allow for:

- Physical and sexual development
- Transition to adolescence
- Re-awakening of emotions about their birth parents or original family

Take into account that these factors can complicate therapeutic interventions and relationships with foster carers, special guardians and adoptive parents. Discuss making contact with their birth parents or original family sensitively.

Interventions for Attachment Difficulties in Children and Young People in Residential Care

Professionals with expertise in attachment difficulties should:

- Work with the residential staff group and identify any key attachment figures to work specifically with the child or young person in residential care

Offer parental sensitivity and behaviour training adapted for professional carers in residential care

Ensure parental sensitivity and behaviour training for professional carers:

- First consists of a single session with the carers followed by at least 5 (and up to 15) weekly or fortnightly carer–child sessions (lasting 60 minutes) over 6 months
- Is delivered by a trained health or social care professional
- Includes:
  - Coaching the residential carers in behavioural management (for children aged 0 to 18 months) and limit setting
  - Reinforcing sensitive responsiveness
  - Ways to improve caring quality
- Homework to practise applying new skills

Modify interventions for young people in residential care when needed to allow for:

- Physical and sexual development
- Transition to adolescence
- Re-awakening of emotions about their birth parents or original family

Take into account that these factors can complicate therapeutic interventions and relationships with professional carers. Discuss making contact with their birth parents or original family sensitively.

Definitions

Strength of Recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group (GDG) makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the GDG is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The GDG usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally the GDG uses 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The GDG uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. Similar forms of words (for example, 'Do not offer…') are used when the GDG is confident that an intervention will not be of benefit for most patients.

Interventions That Could Be Used

The GDG uses 'consider' when confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Clinical Algorithm(s)

A National Institute for Health and Care Excellence (NICE) pathway titled "Attachment difficulties in children and young people overview" is available from the NICE Web site .

Scope

Disease/Condition(s)

Attachment difficulties

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Prevention

Risk Assessment

Clinical Specialty

Family Practice

Pediatrics

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Other

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Guideline Objective(s)

- To make recommendations for the identification, assessment and treatment for attachment

difficulties in children
- To improve access and engagement with treatment and services for children with attachment difficulties and their carers
- To evaluate the role of specific psychological, psychosocial and pharmacological interventions in the treatment of children's attachment
- To evaluate the role of psychological and psychosocial interventions in combination with pharmacological interventions in the treatment of attachment difficulties
- To evaluate the role of specific service-level interventions for people with attachment difficulties
- To integrate the above to provide best-practice advice on the care of individuals throughout the course of their treatment
- To promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the National Health Service (NHS) in England and Wales

Target Population

Children and young people (aged 0-18 years) who are:

Adopted, including those adopted in England from abroad
Looked after children in the care system
At high risk of being taken into care

Special consideration is given to the children of parents with mental health and substance misuse problems and to the needs of groups at increased social disadvantage such as: children and young people from black and minority ethnic groups, those who are unaccompanied immigrants or asylum seekers, and those with disabilities, including learning disabilities.

Note: The following groups are not covered: children and young people with attachment problems or disorders who are not looked after, or who are not at risk of being looked after, or who have not been adopted from the care system (for example, children who are adopted by a relative or step-parent and children who are adopted abroad); adults over the age of 18 years.

Interventions and Practices Considered

1. Ensuring that all children, young people and their parents or carers get equal access to interventions for attachment difficulties
2. Improving the stability of placements
3. Preparing the child or young person before they enter the care system or change placement
4. Improving the likelihood of a more permanent placement, including adoption
5. Preserving the personal history of children and young people
6. Safeguarding and monitoring during interventions
7. Pharmacological interventions (not recommended for treatment of attachment difficulties)
8. Interventions for coexisting mental health conditions according to established guidelines
9. Supporting children and young people with attachment difficulties in schools and other education settings (including early years)
10. Assessing attachment difficulties in children and young people in all health and social care settings
11. Interventions for attachment difficulties in children and young people on the edge of care
    - Video feedback program for parents
    - Parental sensitivity and behaviour training
    - Home visits
    - Parent-child psychotherapy
    - Cognitive behaviour therapy
12. Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care
    - Video feedback program for parents
    - Intensive training and support for foster carers

- Group therapeutic play sessions
- Group-based training and education programmes for fosters carers and children

13. Interventions for attachment difficulties in children and young people in residential care
    - Parental sensitivity and behaviour training adapted for professional carers
    - Modifying interventions when needed to allow for physical and sexual development, transition to adolescence, re-awakening of emotions about birth parents or original family

Major Outcomes Considered

- Disorganised attachment and/or attachment disorders
- Behavioural, cognitive, educational and social functioning
- Wellbeing and quality of life
- Developmental status
- Quality of the relationship between the parent or caregiver and child or young person
- Quality of parenting and parenting behaviour
- Risk factors
- Criminal outcomes
- Experience of interventions and care processes
- The breakdown of fostering and adoption
- Cost-effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): The guideline was developed by the National Collaborating Centre for Mental Health (NCCMH) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of the guideline and related appendices.

The Search Process

Scoping Searches

A broad preliminary search of the literature was undertaken in September 2013 to obtain an overview of the issues likely to be covered by the scope, and to help define key areas. Searches were restricted to clinical guidelines, Health Technology Assessment (HTA) reports, key systematic reviews and randomised controlled trials (RCTs). A list of databases and Web sites searched can be found in Appendix H.

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate as much relevant evidence as possible. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a broad approach to searching to maximise retrieval of evidence to all parts of the guideline. Searches were restricted to certain study designs if specified in the review

protocol, and conducted in the following databases:

- Applied Social Sciences Index and Abstracts
- British Education Index
- Cochrane Central Register of Controlled Trials
- Cochrane Database of Abstracts of Reviews of Effects
- Cochrane Database of Systematic Reviews
- Cumulative Index to Nursing and Allied Health Literature
- Excerpta Medica Database (EMBASE)
- Education Resources Information Center
- HTA database (technology assessments)
- International Bibliography of the Social Sciences
- Medical Literature Analysis and Retrieval System Online (MEDLINE)/MEDLINE In-Process
- Psychological Information Database (PsycINFO)
- Social Care Online
- Social Services Abstracts
- Sociological Abstracts

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up through a number of trial searches and discussions of the results of the searches with the review team and Guideline Committee (GC) to ensure that all possible relevant search terms were covered. In order to assure comprehensive coverage, search terms for the topic area were kept purposely broad to help counter dissimilarities in database indexing practices and thesaurus terms, and imprecise reporting of study populations by authors in the titles and abstracts of records. The search terms for each search are set out in full in Appendix H.

Reference Management

Citations from each search were downloaded into EndNote reference management software and duplicates removed. Records were then screened against the eligibility criteria of the reviews before being appraised for methodological quality (see below). The unfiltered search results were saved and retained for future potential re-analysis to help keep the process both replicable and transparent.

Search Filters

To aid retrieval of relevant and sound studies, filters were used to limit a number of searches to systematic reviews, RCTs and observational studies. The search filters for systematic reviews and RCTs are adaptations of filters designed by McMaster University. The observational study filter was developed in-house. Each filter comprises index terms relating to the study type(s) and associated text-words for the methodological description of the design(s).

Date and Language Restrictions

Systematic database searches were initially conducted in December 2013 up to the most recent searchable date. Search updates were generated on a 6-monthly basis, with the final re-runs carried out in February 2015 ahead of the guideline consultation. After this point, studies were only included if they were judged by the GC to be exceptional (for example, if the evidence was likely to change a recommendation).

Although no language restrictions were applied at the searching stage, foreign language papers were not requested or reviewed, unless they were of particular importance to a review question.

Date restrictions were not applied, except for searches of systematic reviews which were limited to research published from 2000 as older reviews were thought to be less useful.

Other Search Methods

Other search methods involved: (a) scanning the reference lists of all eligible publications (systematic reviews, stakeholder evidence and included studies) for more published reports and citations of

unpublished research; (b) sending lists of studies meeting the inclusion criteria to subject experts (identified through searches and the GC) and asking them to check the lists for completeness, and to provide information of any published or unpublished research for consideration (see Appendix H); (c) checking the tables of contents of key journals for studies that might have been missed by the database and reference list searches; (d) tracking key papers in the Science Citation Index (prospectively) over time for further useful references; (e) conducting searches in ClinicalTrials.gov for unpublished trial reports; (f) contacting included study authors for unpublished or incomplete datasets. Searches conducted for existing NICE guidelines were updated where necessary. Other relevant guidelines were assessed for quality using the Appraisal of Guidelines for Research and Evaluation Instrument (AGREE) instrument. The evidence base underlying high-quality existing guidelines was utilised and updated as appropriate.

Full details of the search strategies and filters used for the systematic review of clinical evidence are provided in Appendix H.

Study Selection and Assessment of Methodological Quality

All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time they were being entered into the study information database. More specific eligibility criteria were developed for each review question and are described in the relevant clinical evidence chapters. Eligible systematic reviews and primary-level studies were critically appraised for methodological quality (risk of bias) using a checklist (see *The Guidelines Manual* for templates; see the "Availability of Companion Documents" field). The eligibility of each study was confirmed by at least 1 member of the GC.

For some review questions, it was necessary to prioritise the evidence with respect to the United Kingdom (UK) context. To make this process explicit, the GC took into account the following factors when assessing the evidence:

- Participant factors (for example, gender, age and ethnicity)
- Provider factors (for example, model fidelity, the conditions under which the intervention was performed and the availability of experienced staff to undertake the procedure)
- Cultural factors (for example, differences in standard care and differences in the welfare system)

It was the responsibility of the GC to decide which prioritisation factors were relevant to each review question in light of the UK context. Evidence from other country settings was still included in the reviews and contributed to the meta-analysis. Therefore, their data were not downgraded for indirectness. Rather, when the GC generated recommendations (for instance, on interventions to treat attachment difficulties, such as home visiting programmes) the detail included on the number of sessions, frequency, duration and so on were mostly extracted from UK studies.

Unpublished Evidence

Stakeholders, authors and principle investigators were approached for unpublished evidence (see Appendix E). The GC used a number of criteria when deciding whether or not to accept unpublished data. First, the evidence must have been accompanied by a trial report containing sufficient detail to properly assess risk of bias. Second, the evidence must have been submitted with the understanding that data from the study and a summary of the study's characteristics would be published in the full guideline. Therefore, in most circumstances the GC did not accept evidence submitted 'in confidence'. However, the GC recognised that unpublished evidence submitted by investigators might later be retracted by those investigators if the inclusion of such data would jeopardise publication of their research.

Health Economics Methods

The aim of the health economics was to contribute to the guideline's development by providing evidence on the cost effectiveness of interventions for the promotion of attachment in children and young people who are adopted from care, in care or on the edge of care covered in the guideline. This was achieved by systematic literature review of existing economic evidence and decision-analytic economic modelling.

Search Strategy for Economic Evidence

Scoping Searches

A broad preliminary search of the literature was undertaken in September 2013 to obtain an overview of the issues likely to be covered by the scope, and help define key areas. Searches were restricted to economic studies and HTA reports, and conducted in the following databases:

EMBASE
MEDLINE/MEDLINE In-Process
HTA database (technology assessments)
National Health Service (NHS) Economic Evaluation Database

Any relevant economic evidence arising from the clinical scoping searches was also made available to the health economist during the same period.

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision was made to utilise a broad approach to searching to maximise retrieval of evidence to all parts of the guideline. Searches were restricted to economic studies and HTA reports, and conducted in the following databases:

American Economic Association's electronic bibliography
EMBASE
HTA database (technology assessments)
MEDLINE/MEDLINE In-Process
NHS Economic Evaluation Database
PsycINFO

Any relevant economic evidence arising from the clinical searches was also made available to the health economist during the same period.

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up through a number of trial searches, and discussions of the results of the searches with the review team and GC to ensure that all possible relevant search terms were covered. In order to assure comprehensive coverage, search terms for the guideline topic were kept purposely broad to help counter dissimilarities in database indexing practices and thesaurus terms, and imprecise reporting of study populations by authors in the titles and abstracts of records.

For standard mainstream bibliographic databases (EMBASE, MEDLINE and PsycINFO) search terms for the guideline topic were combined with a search filter for health economic studies. For searches generated in topic-specific databases (HTA, NHS Economic Evaluation Database) search terms for the guideline topic were used without a filter. The sensitivity of this approach was aimed at minimising the risk of overlooking relevant publications, due to potential weaknesses resulting from more focused search strategies. The search terms are set out in full in Appendix I.

Reference Management

Citations from each search were downloaded into EndNote reference management software and duplicates removed. Records were then screened against the inclusion criteria of the reviews before being quality appraised. The unfiltered search results were saved and retained for future potential re-analysis to help keep the process both replicable and transparent.

Search Filters

The search filter for health economics is an adaptation of a pre-tested strategy designed by the Centre

for Reviews and Dissemination (2015). The search filter is designed to retrieve records of economic evidence (including full and partial economic evaluations) from the vast amount of literature indexed to major medical databases such as MEDLINE. The filter, which comprises a combination of controlled vocabulary and free-text retrieval methods, maximises sensitivity (or recall) to ensure that as many potentially relevant records as possible are retrieved from a search. A full description of the filter is provided in Appendix I.

Date and Language Restrictions

Systematic database searches were initially conducted in December 2013 up to the most recent searchable date. Search updates were generated on a 6-monthly basis, with the final re-runs carried out in February 2015. After this point, studies were included only if they were judged by the GC to be exceptional (for example, the evidence was likely to change a recommendation).

Although no language restrictions were applied at the searching stage, foreign language papers were not requested or reviewed, unless they were of particular importance to an area under review. All the searches were restricted to research published from 1999 onwards in order to obtain data relevant to current healthcare settings and costs.

Other Search Methods

Other search methods involved scanning the reference lists of all eligible publications (systematic reviews, stakeholder evidence and included studies from the economic and clinical reviews) to identify further studies for consideration.

Full details of the search strategies and filter used for the systematic review of health economic evidence are provided in Appendix I.

Inclusion Criteria for Economic Studies

The following inclusion criteria were applied to select studies identified by the economic searches for further consideration:

Only studies from countries in the Organisation for Economic Co-operation and Development were included, because the aim of the review is to identify economic information transferable to the UK context.
Selection criteria based on types of clinical conditions and service users as well as interventions assessed were identical to the clinical literature review.
Studies were included provided that sufficient details regarding methods and results were available to enable the methodological quality of the study to be assessed, and provided that the study's data and results were extractable. Poster presentations and conference abstracts were excluded.
Full economic evaluations that compared 2 or more relevant options and considered both costs and consequences as well as costing analyses that compared only costs between 2 or more interventions were included in the review.
Economic studies were included if they used clinical effectiveness data from an RCT, a prospective cohort study, or a systematic review and meta-analysis of clinical studies. Studies that had a mirror-image or other retrospective design were also included in the review.
Studies were included only if the examined interventions were clearly described. This involved the types of health professionals involved as well as the frequency and duration of treatment.
Studies that adopted a very narrow perspective, ignoring major categories of costs to the NHS, were excluded. Such studies were considered non-informative to the guideline development process.

Results of the Systematic Search of Economic Literature

The titles of all studies identified by the systematic search of the literature were screened for their relevance to the topic (that is, economic issues and information on health-related quality of life). References that were clearly not relevant were excluded first. The abstracts of all potentially relevant studies (29 references) were then assessed against the inclusion criteria for economic evaluations by the

health economist. Full texts of the studies potentially meeting the inclusion criteria (including those for which eligibility was not clear from the abstract) were obtained. Studies that did not meet the inclusion criteria, were duplicates, were secondary publications of 1 study, or had been updated in more recent publications were subsequently excluded. Economic evaluations eligible for inclusion (3 studies in 4 publications) were then appraised for their applicability and quality using the methodology checklist for economic evaluations. Finally, those studies that fully or partially met the applicability and quality criteria were considered at formulation of the guideline recommendations.

Number of Source Documents

See Appendices H-L (see the "Availability of Companion Documents" field) for detailed information on results of literature searches, number of included and excluded studies, and evidence tables for each review question. Also see Appendix M for a list of excluded studies. The flow diagrams of the systematic literature searches for both clinical and economic evidence can be found in Appendix P.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Overall Quality of Outcome Evidence in Grading of Recommendations Assessment, Development and Evaluation (GRADE)

Level	Description
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
Low	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
Very Low	Any estimate of effect is very uncertain.

Methods Used to Analyze the Evidence

Meta-Analysis

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): The guideline was developed by the National Collaborating Centre for Mental Health (NCCMH) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of the guideline and related appendices.

Clinical Review Methods

Data Extraction

Quantitative Analysis

Study characteristics, aspects of methodological quality, and outcome data were extracted from all

eligible studies, using Review Manager 5.3.5 and/or electronic data extraction templates (see Appendices J and K).

In most circumstances, for a given outcome (continuous and dichotomous), where more than 50% of the number randomised to any group were missing or incomplete, the study results were excluded from the analysis (except for the outcome 'leaving the study early', in which case, the denominator was the number randomised). Where there were limited data for a particular review, the 50% rule was not applied. In these circumstances the evidence was downgraded.

Where possible, outcome data from an intention-to-treat analysis (ITT) (that is, a 'once-randomised-always-analyse' basis) were used. Where ITT had not been used or there were missing data, the effect size for dichotomous outcomes were recalculated using best-case and worse-case scenarios. Where conclusions varied between scenarios, the evidence was downgraded.

Where some of the studies failed to report standard deviations (for a continuous outcome), and where an estimate of the variance could not be computed from other reported data or obtained from the study author, the following approach was taken based on that suggested by Furukawa and colleagues (2006). When the number of studies with missing standard deviations was less than one-third and when the total number of studies was at least ten, the pooled standard deviation was imputed (calculated from all the other studies in the same meta-analysis that used the same version of the outcome measure). In this case, the appropriateness of the imputation was made by comparing the standardised mean differences (SMDs) of those trials that had reported standard deviations against the hypothetical SMDs of the same trials based on the imputed standard deviations. If they converged, the meta-analytical results were considered to be reliable.

When the conditions above could not be met, standard deviations were taken from another related systematic review (if available). In this case, the results were considered to be less reliable.

The meta-analysis of survival data, such as time to any mood episode, was based on log hazard ratios (HRs) and standard errors. Since individual participant data were not available in included studies, hazard ratios and standard errors calculated from a Cox proportional hazards model were extracted. Where necessary, standard errors were calculated from confidence intervals or *p* value according to standard formulae; see the *Cochrane Reviewers' Handbook* 5.1.0. Data were summarised using the generic inverse variance method using Review Manager.

Consultation with another reviewer or members of the Guideline Committee (GC) was used to overcome difficulties with coding. Data from studies included in existing systematic reviews were extracted independently by 1 reviewer and cross-checked with the existing dataset. Where possible, 2 independent reviewers extracted data from new studies. Where double data extraction was not possible, data extracted by 1 reviewer was checked by the second reviewer. Disagreements were resolved through discussion. Where consensus could not be reached, a third reviewer or GC members resolved the disagreement. Masked assessment (that is, blind to the journal from which the article comes, the authors, the institution and the magnitude of the effect) was not used since it is unclear that doing so reduces bias.

Evidence Synthesis

The method used to synthesise evidence depended on the review question and availability and type of evidence (see Appendix F in the full guideline appendices). Briefly, for questions about the psychometric properties of instruments, reliability, validity and clinical utility were synthesised narratively based on accepted criteria. For questions about test accuracy, bivariate test accuracy meta-analysis was conducted where appropriate. For questions about the effectiveness of interventions, standard meta-analysis or network meta-analysis was used where appropriate, otherwise narrative methods were used with clinical advice from the GC. In the absence of high-quality research, an informal consensus process was used.

Grading the Quality of Evidence

For questions about the effectiveness of interventions, the Grading of Recommendations Assessment,

Development and Evaluation (GRADE) approach was used to grade the quality of evidence for each outcome. For questions about the experience of care and the organisation and delivery of care, methodology checklists were used to assess the risk of bias, and this information was taken into account when interpreting the evidence. The technical team produced GRADE evidence profiles (see below) using GRADEprofiler (GRADEpro) software (Version 3.6), following advice set out in the GRADE handbook. All staff doing GRADE ratings were trained, and calibration exercises were used to improve reliability.

Evidence Profiles

A GRADE evidence profile was used to summarise both the quality of the evidence and the results of the evidence synthesis for each 'critical' and 'important' outcome (see Table 4 in the full version of the guideline for an example of an evidence profile). The GRADE approach is based on a sequential assessment of the quality of evidence, followed by judgment about the balance between desirable and undesirable effects, and subsequent decision about the strength of a recommendation.

Within the GRADE approach to grading the quality of evidence, the following is used as a starting point:

> Randomised controlled trials (RCTs) without important limitations provide high-quality evidence
> Observational studies without special strengths or important limitations provide low-quality evidence

For each outcome, quality may be reduced depending on 5 factors: limitations, inconsistency, indirectness, imprecision and publication bias. For the purposes of the guideline, each factor was evaluated using criteria provided in Table 5 in the full guideline appendices.

For observational studies without any reasons for down-grading, the quality may be upgraded if there is a large effect, all plausible confounding would reduce the demonstrated effect (or increase the effect if no effect was observed), or there is evidence of a dose-response gradient (details would be provided under the 'other' column).

Each evidence profile includes a summary of findings: number of participants included in each group, an estimate of the magnitude of the effect, and the overall quality of the evidence for each outcome. Under the GRADE approach, the overall quality for each outcome is categorised into 1 of 4 groups (high, moderate, low, very low) (see the "Rating Scheme for the Strength of the Evidence" field).

Presenting Evidence to the Guideline Committee

Study characteristics tables and, where appropriate, forest plots generated with Review Manager Version 5.3.5 and GRADE summary of findings tables (see below) were presented to the GC.

Where meta-analysis was not appropriate and/or possible, the reported results from each primary-level study were reported in the study characteristics table and presented to the GC. The range of effect estimates were included in the GRADE profile, and where appropriate, described narratively.

Summary of Findings Tables

Summary of findings tables generated from GRADEpro were used to summarise the evidence for each outcome and the quality of that evidence (see Table 6 in the full version of the guideline). The tables provide illustrative comparative risks, especially useful when the baseline risk varies for different groups within the population.

Extrapolation

When answering review questions, if there is no direct evidence from a primary dataset (a dataset which contains evidence on the population and intervention under review) based on the initial search for evidence, it may be appropriate to extrapolate from another data set. Refer to Section 3.5.6 in the full version of the guideline for additional discussion of the principles of extrapolation.

Method Used to Answer a Review Question in the Absence of Appropriately Designed, High-Quality Research

In the absence of appropriately designed, high-quality research (including indirect evidence where it would be appropriate to use extrapolation), an informal consensus process was adopted.

For some outcomes, the process involved a member of the GC or review team drafting a statement about what is known about the issue based on expert opinion from existing narrative reviews. The statement was circulated to the GC and used as the basis of a group discussion.

For other outcomes, the process involved a group discussion of what is known about the issues. The views of GC were synthesised narratively by a member of the review team, and circulated after the meeting. Feedback was used to revise the text, which was then included in the appropriate evidence review chapter.

Health Economics Methods

The aim of the health economics was to contribute to the guideline's development by providing evidence on the cost-effectiveness of interventions for the promotion of attachment in children and young people who are adopted from care, in care or on the edge of care covered in the guideline.

This was achieved by:

- Systematic literature review of existing economic evidence
- Decision-analytic economic modelling

Systematic reviews of economic literature were conducted in all areas covered in the guideline. Economic modelling was undertaken in areas with likely major resource implications, where the current extent of uncertainty over cost-effectiveness was significant and economic analysis was expected to reduce this uncertainty, in accordance with *The Guidelines Manual* (NICE, 2014). Prioritisation of areas for economic modelling was a joint decision between the Health Economist and the GC. The rationale for prioritising review questions for economic modelling was set out in an economic plan agreed between NICE, the GC, the Health Economist and the other members of the technical team. The following economic question was selected as the key issue that was addressed by economic modelling:

- Psychosocial and psychological interventions for the promotion of attachment in children and young people on the edge of care

In addition, literature on the health-related quality of life of children and young people with attachment difficulties was systematically searched to identify studies reporting appropriate utility scores that could be utilised in a cost-utility analysis. Methods employed in economic modelling are described in the relevant economic sections of the evidence chapters of the full version of the guideline.

Applicability and Quality Criteria for Economic Studies

All economic papers eligible for inclusion were appraised for their applicability and quality using the methodology checklist for economic evaluations recommended by NICE. The methodology checklist for economic evaluations was also applied to the model-based economic analyses undertaken specifically for this guideline. All studies that fully or partially met the applicability and quality criteria described in the methodology checklist were considered during the guideline development process, along with the results of the economic modelling conducted specifically for this guideline. The completed methodology checklists for all economic evaluations considered in the guideline are provided in Appendix Q.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): The guideline was developed by the National Collaborating Centre for Mental Health (NCCMH) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of the guideline and related appendices.

The Guideline Committee

During the consultation phase, members of the Guideline Committee (GC) were appointed by an open recruitment process. GC membership consisted of: professionals in psychiatry, clinical psychology, education and social work; academic experts in psychiatry and psychology; and care leavers, carers and representatives from service user and carer organisations. The guideline development process was supported by staff from the NCCMH, who undertook the clinical and health economic literature searches, reviewed and presented the evidence to the GC, managed the process, and contributed to drafting the guideline.

Guideline Committee Meetings

Eleven GC meetings were held between December 2013 and July 2015. During each day-long GC meeting, in a plenary session, review questions and clinical and economic evidence were reviewed and assessed, and recommendations formulated. At each meeting, all GC members declared any potential conflicts of interest (see Appendix B), and care-leaver and carer concerns were routinely discussed as a standing agenda item.

Care Leavers and Carers

Individuals with direct experience of services gave an integral care-leaver and service-user focus to the GC and the guideline. The GC included 2 care leavers and 2 carer representatives. They contributed as full GC members to writing the review questions, providing advice on outcomes most relevant to care leavers and carers, helping to ensure that the evidence addressed their views and preferences, highlighting sensitive issues and terminology relevant to the guideline, and bringing service user research to the attention of the GC. In drafting the guideline, they contributed to writing the guideline's introduction and identified recommendations from the care-leaver and carer perspective.

Special Advisors

Special advisors, who had specific expertise in 1 or more aspects of treatment and management relevant to the guideline, assisted the GC, commenting on specific aspects of the developing guideline and making presentations to the GC. Appendix C lists those who agreed to act as special advisors.

National and International Experts

National and international experts in the area under review were identified through the literature search and through the experience of the GC members. These experts were contacted to identify unpublished or soon-to-be published studies, to ensure that up-to-date evidence was included in the development of the guideline. They informed the GC about completed trials at the pre-publication stage, systematic reviews in the process of being published, studies relating to the cost-effectiveness of treatment and trial data if the GC could be provided with full access to the complete trial report. Appendix E lists researchers who were contacted.

Review Protocols

Review questions drafted during the scoping phase were discussed by the GC at the first few meetings and amended as necessary. The review questions were used as the starting point for developing review protocols for each systematic review. Where appropriate, the review questions were refined once the evidence had been searched and, where necessary, sub-questions were generated. The final list of review questions can be found in Appendix F.

For questions about interventions, the PICO (Population, Intervention, Comparison and Outcome) framework was used to structure each question (see Table 2 in the full guideline).

Questions relating to diagnosis or case identification do not involve an intervention designed to treat a particular condition, and therefore the PICO framework was not used. Rather, the questions were designed to pick up key issues specifically relevant to clinical utility, for example their accuracy, reliability, safety and acceptability to the service user.

In some situations, the prognosis of a particular condition is of fundamental importance, over and above its general significance in relation to specific interventions. Areas where this is particularly likely to occur relate to assessment of risk, for example in terms of behaviour modification or screening and early intervention. In addition, review questions related to issues of service delivery are occasionally specified in the remit from the Department of Health. In these cases, appropriate review questions were developed to be clear and concise.

For each topic, addressed by 1 or more review questions, a review protocol was drafted by the technical team using a standardised template (based on PROSPERO). After a protocol was finalised by the GC, registration on the PROSPERO Web site was performed for those likely to be published in peer-reviewed journals. All protocols are included in Appendix F.

To help facilitate the literature review, a note was made of the best study design type to answer each question. There are 4 main types of review question of relevance to NICE guidelines, which are listed in Table 3 in the full version of the guideline. For each type of question, the best primary study design varies, where 'best' is interpreted as 'least likely to give misleading answers to the question'. For questions about the effectiveness of interventions, where randomised controlled trials (RCTs) were not available, the review of other types of evidence was pursued only if there was reason to believe that it would help the GC to formulate a recommendation.

However, in all cases, a well-conducted systematic review (of the appropriate type of study) is likely to always yield a better answer than a single study.

Clinical Review Methods

The aim of the clinical literature review was to systematically identify and synthesise relevant evidence from the literature in order to answer the specific review questions developed by the GC. Thus, clinical practice recommendations are evidence-based, where possible, and, if evidence is not available, informal consensus methods are used to try and reach general agreement between GC members and the need for future research is specified.

From Evidence to Recommendations

Once the clinical and health economic evidence was summarised, the GC drafted the recommendations. In making recommendations, the GC took into account the trade-off between the benefits and harms of the intervention/instrument, as well as other important factors, such as economic considerations, values of the GC and society, the requirements to prevent discrimination and to promote equality, and the GC's awareness of practical issues.

Finally, to show clearly how the GC moved from the evidence to the recommendations, each chapter has a section called 'from evidence to recommendations'. Underpinning this section is the concept of the 'strength' of a recommendation. This takes into account the quality of the evidence but is conceptually different. Some recommendations are 'strong' in that the GC believes that the vast majority of healthcare professionals and service users would choose a particular intervention if they considered the evidence in the same way that the GC has. This is generally the case if the benefits clearly outweigh the harms for most people and the intervention is likely to be cost effective. However, there is often a closer balance between benefits and harms, and some service users would not choose an intervention whereas others would. This may happen, for example, if some service users are particularly averse to some side effect and others are not. In these circumstances the recommendation is generally weaker, although it may be possible to make stronger recommendations about specific groups of service users. The strength of each recommendation is reflected in the wording of the recommendation, rather than by using ratings, labels or symbols.

Where the GC identified areas in which there are uncertainties or where robust evidence was lacking, they developed research recommendations. Those that were identified as 'high priority' were developed further in the NICE version of the guideline, and presented in Appendix G.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group (GDG) makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the GDG is confident that, given the information it has looked at, most people would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The GDG usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally 'must' (or 'must not') is used if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The GDG uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of people, an intervention will do more good than harm, and be cost effective. The GDG uses similar forms of words (for example, 'Do not offer…') when they are confident that an intervention will not be of benefit for most people.

Interventions That Could Be Used

The GDG uses 'consider' when confident that an intervention will do more good than harm for most people, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the person's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the person.

Cost Analysis

Presentation of Economic Evidence

The economic evidence considered in the guideline is provided in the respective evidence chapters, following presentation of the relevant clinical evidence. The references to included studies and the respective evidence tables with the study characteristics and results are provided in Appendix R (see the "Availability of Companion Documents" field). Methods and results of economic modelling undertaken alongside the guideline development process are presented in the relevant evidence chapters. Characteristics and results of all economic studies considered during the guideline development process (including modelling studies conducted for this guideline) are summarised in economic evidence profiles accompanying respective Grading of Recommendations Assessment, Development and Evaluation (GRADE) tables.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Stakeholder Contributions

Professionals, service users, and companies have contributed to and commented on the guideline at key stages in its development. Stakeholders for this guideline include:

- Service user and carer stakeholders: national service user and carer organisations that represent the interests of people whose care will be covered by the guideline
- Local service user and carer organisations: but only if there is no relevant national organisation
- Professional stakeholders' national organisations: that represent the healthcare professionals who provide the services described in the guideline
- Commercial stakeholders: companies that manufacture drugs or devices used in treatment of the condition covered by the guideline and whose interests may be significantly affected by the guideline
- Providers and commissioners of health services in England
- Statutory organisations: including the Department of Health, the Care Quality Commission and the National Patient Safety Agency
- Research organisations: that have carried out nationally recognised research in the area

The National Institute for Health and Care Excellence (NICE) clinical guidelines are produced for the National Health Service (NHS) in England, so a 'national' organisation is defined as one that represents England, or has a commercial interest in England.

Stakeholders have been involved in the guideline's development at the following points:

- Commenting on the initial scope of the guideline and attending a scoping workshop held by NICE
- Contributing possible review questions and lists of evidence to the Guideline Committee (GC)
- Commenting on the draft of the guideline

Validation of the Guideline

Registered stakeholders had an opportunity to comment on the draft guideline, which was posted on the NICE Web site during the consultation period. Following the consultation, all comments from stakeholders and experts (see Appendix D [see the "Availability of Companion Documents" field]) were responded to, and the guideline updated as appropriate. NICE also reviewed the guideline and checked that stakeholders' comments had been addressed.

Following the consultation period, the GC finalised the recommendations and the National Collaborating Centre for Mental Health (NCCMH) produced the final documents. These were then submitted to NICE for a quality assurance check. Any errors were corrected by the NCCMH, then the guideline was formally approved by NICE and issued as guidance to the NHS in England.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type and quality of evidence supporting each review question are described in evidence profiles in the full version of the guideline (see the "Availability of Companion Documents" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

This guideline will help professionals ensure that children presenting with characteristics that suggest difficulties with attachment are diagnosed accurately and that their needs are addressed quickly. The guideline will be useful to clinicians and service commissioners in providing and planning high-quality care for children with attachment difficulties while also emphasising the importance of the experience of care for children with attachment difficulties and their carers.

Refer to the "Trade-off between benefits and harms" sections in the full version of the guideline (see the "Availability of Companion Documents" field) for details about benefits of specific interventions.

Potential Harms

Unstable placements are associated with poorer mental health, behavioural problems, and early exit from care. As adults, these children have poorer employment and education outcomes, and higher involvement with the criminal justice system.

Refer to the "Trade-off between benefits and harms" sections in the full version of the guideline (see the "Availability of Companion Documents" field) for details about harms of specific interventions.

Qualifying Statements

Qualifying Statements

- Healthcare professionals are expected to take the National Institute for Health and Care Excellence (NICE) clinical guidelines fully into account when exercising their clinical judgement. However, the guidance does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer.
- Refer to the "Uses and limitations of clinical guidelines" section in the full version of the guideline for additional information.

Implementation of the Guideline

Description of Implementation Strategy

See the section "Children's attachment implementation: getting started" in the original guideline document for information that could have a big impact on practice and be challenging to implement, along with the reason(s) why there are proposed change in these areas. The section also gives information on resources to help with implementation.

Key Priorities for Implementation

The following recommendations have been identified as priorities for implementation.

Principles of Care in All Contexts

Ensure that all children, young people and their parents or carers get equal access to interventions for attachment difficulties regardless of whether they:

Are on the edge of care, accommodated under Section 20 of the Children Act 1989
, subject to a care order, under special guardianship or adopted from care
Are placed with birth parents, foster carers (including kinship carers), special guardians or in residential care
Are from a minority ethnic group

Have a disability or a mental health problem
Are from the United Kingdom (UK) or overseas

Ensure that the health, education and social care processes and structures surrounding children and young people with attachment difficulties are stable and consistent. This should include:

Using a case management system to coordinate care and treatment
Collaborative decision making among all health, education and social care professionals, the child or young person if possible and their parents and carers
Having the same key worker, social worker or personal adviser or key person in school throughout the period the child or young person is in the care system or on the edge of care

Supporting Children with Attachment Difficulties in Schools

Schools and other education providers should ensure that all staff who may come into contact with children and young people with attachment difficulties receive appropriate training on attachment difficulties.

Assessing Attachment Difficulties in Children and Young People in All Health and Social Care Settings

Health and social care provider organisations should train key workers, social care workers, personal advisers and post-adoption support social workers in the care system, as well as workers involved with children and young people on the edge of care, in:

Recognising and assessing attachment difficulties and parenting quality, including parental sensitivity
Recognising and assessing multiple socioeconomic factors (for example, low income, single or teenage parents) that together are associated with an increased risk of attachment difficulties
Recognising and assessing other difficulties, including coexisting mental health problems and the consequences of maltreatment, including trauma
Knowing when and how to refer for evidence-based interventions for attachment difficulties

Interventions for Children and Young People on the Edge of Care

Health and social care professionals should offer a video feedback programme to the parents of preschool-age children on the edge of care to help them:

Improve how they nurture their child, including when the child is distressed
Improve their understanding of what their child's behaviour means
Respond positively to cues and expressions of the child's feelings
Behave in ways that are not frightening to the child
Improve mastery of their own feelings when nurturing the child

Interventions for Attachment Difficulties in Children and Young People in the Care System, Subject to Special Guardianship Orders and Adopted from Care

Preschool-age Children

Health and social care professionals should offer a video feedback programme to foster carers, special guardians and adoptive parents.

Primary School-age Children

Consider intensive training and support for foster carers, special guardians and adoptive parents before the placement and for 9 to 12 months after, combined with group therapeutic play sessions for the child for the same duration.

Late Primary and Secondary School-age Children

Consider a group-based training and education programme for foster carers, special guardians and

adoptive parents to maintain stability in the home and help transition to a new school environment, combined with a group-based training and education programme for late primary and early secondary school-age children and young people in the care system, subject to special guardianship orders and adopted from care to improve social skills and maintain positive peer relationships.

Modify interventions for young people in the care system, subject to special guardianship orders and adopted from care when needed to allow for:

- Physical and sexual development
- Transition to adolescence
- Re-awakening of emotions about their birth parents or original family

Take into account that these factors can complicate therapeutic interventions and relationships with foster carers, special guardians and adoptive parents. Discuss making contact with their birth parents or original family sensitively.

Implementation Tools

Clinical Algorithm

Mobile Device Resources

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

National Collaborating Centre for Mental Health. Childrenâ€™s attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Nov 25. 42 p. (NICE guideline; no. 26).

Adaptation

Not applicable: The guideline was not adapted from another source.

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Guideline Committee

Guideline Committee

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Financial Disclosures/Conflicts of Interest

All Guideline Committee (GC) members made formal declarations of interest at the outset, which were updated at every GC meeting. GC declarations of interest are provided in Appendix B in the full guideline appendices (see the "Availability of Companion Documents" field).

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the National Institute for Health and Care Excellence (NICE) Web site . Also available for download in eBook and ePub formats from the NICE Web site .

Availability of Companion Documents

The following are available:

- Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. Full guideline. London (UK): National Institute for Health and Care Excellence; 2015 Nov. 496 p. (NICE guideline; no. 26). Available from the National Institute for Health and Care Excellence (NICE) Web site .
- Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. Appendices. London (UK): National Institute for Health and Care Excellence; 2015 Nov. (NICE guideline; no. 26). Available from the NICE Web site .
- Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. Baseline assessment tool. London (UK): National Institute for Health and Care Excellence; 2015 Nov 25. (NICE guideline; no. 26). Available from the NICE Web site .
- Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. Costing statement. London (UK): National Institute for Health and Care Excellence; 2015 Nov 25. 8 p. (NICE guideline; no. 26). Available from the NICE Web site .
- The guidelines manual 2012. London (UK): National Institute for Health and Care Excellence (NICE); 2012 Nov. Available from the NICE Web site .
- Developing NICE guidelines: the manual. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Oct. Available from the NICE Web site .

Patient Resources

The following is available:

- Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. Information for the public. London (UK): National Institute for

Health and Care Excellence (NICE); 2015 Nov 25. 10 p. Available from the National Institute for Health and Care Excellence (NICE) Web site. Also available for download in eBook and ePub formats from the NICE Web site.

NGC Status

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